

MDPB Minutes from January 22, 2004

Members Present: D. McKelway; B. Collamore; D. Stuchiner; K. Kendall; P. Liebow; D. Ettinger; S. Diaz

MEMS Staff: D. Corning

Regional Coordinators: R. Petrie; J. LeBrun

Guests: J. Regis; K. Marston; J. McKenney; S. Hludik; T. Judge; R. Jarbox; P. Marcolini; L. Metayer; B. Dunwoody; A. Azarra

Excused: E. Smith, J. Bradshaw

Opening Remarks

1. Intro of Dr. McKelway
2. Show and tell of AED's
3. Minutes accepted from November 2003—First by Stuchiner, Second by Kendall, unanimous approval

Old Business

4. Legislative Update by Dwight—Legislature in session; Department bill has made it out of committee; AVOC is out an additional two years; Please refer to Bradshaw's e-mail following the meeting last week.

5. Maine EMS study—Dwight reports we have intent to contract with chosen company. Please refer to Bradshaw's e-mail as per previous item.

6. C-spine study has been completed; discussion of recent C-spine study in NEJM December 25, 2003 p. 2510 by Stiell *et al* re: Canadian C-spine rules—discussion of how they interpreted NEXUS and how differences in country cultures may influence chosen tool.

7. Cardiac Care Committee—Per recent ACEP Maine meeting in December 2003, no difference in transport of patients with ACS at this point, that is to go to closest hospital with ED triage/Rx dictating those to go for primary catheterization. Much discussion with Kendall leading re: future developments including field stratification of such patients, as well—if medics are sure they have ST elevation and equidistant from two hospitals, should they go to PCI center, also—what is the time difference on deciding which hospital to go to.

Action: First—need to have 12 lead EKG as number priority in those with chest pain and work this through the protocol group..

Second: Until field interpretation of EKGs is found to be standardized and appropriate, diversion cannot be accomplished. Train and QI medics so that EKG interpretation is reliable to ensure proper ID of ACS patients; and then see if the state of Maine would benefit from some type of field triage if the literature supports this and the infrastructure supports this.

Third, Kendall will write follow-up article for the journal so that medics are not diverting patients at this point since we agree to take this one step at a time.

Fourth: Diaz will talk with Bradshaw about forming a Cardiac Care Committee to be sure that we keep our protocols and training up-to-date. This will include MDPB members and interested cardiologists, atleast one from each of the hospitals performing interventional cardiology.

8. Airway—after much looking, Diaz found www.ncccp.org to have algorithms that we can copy (thank you Greg Mears). Remarkably, these are similar to the definitions in our algorithm. I will attach our working document to this mailing and encourage all to look at above web site.

Action: Will meet with education committee to see what they need from the MDPB—a book may exist that meets our needs. I will attach our document.

New

9. IO—Lifeflight of Maine has asked to relook at the sternal IO that has been revamped. They have a QI sheet which they will add a line about looking at operator problem with removing device. They will have this as a one year study with a 6 month check up with us. May include land services and ask education and ops to select some organizations that can give us numbers and be compliant with QI. This is not a protocol at this point! The land services will omit the animal lab which is done in many venues, and we will see if any performance differences are noted.

Action: Motion to accept this by McKelway and second by Stuchiner with unanimous acceptance. All actions per discussion as above.

10. Division of Protocols with the caveat that we help each other. White/Purple/Brown—Liebow; Blue—Collamore, Red—Kendall, Gold—McKelway, Green—Stuchiner, Yellow/Pink—Ettinger, Gray—Bradshaw/Diaz; Cover Photo—Smith

Action: Members to peruse their sections and any others of interest and Diaz will attach some preliminary work—Diaz has asked Barbara Covey, MD who teaches Sexual Assault Nurse Examiners about a sexual assault approach and Larry Ricci, MD about a child abuse approach. Diaz will send these as they come in.

11. CCT—Discussed with Medical Directors weighing in first as to what we need. Ettinger—limited usefulness with low number of calls; McKelway—Deferred; Collamore—MUBC attended by some medics in her region and they liked the education but found the practicality limited and suggest we should be able to provide some advanced level without the MUBC level; Stuchiner—Keep the status quo because PIFT has been expanded and we have Lifeflight and too much dilution is bad; Kendall—we need more scene CCT; Liebow—Feels he is somewhere between Stuchiner and Kendall

and sees a role for CCT with Lifeflight but the state needs a small cadre of CCT people and perhaps we need some sort of “Bridge Service.”

Opened the discussion and Marcolini represented the education committee with the thoughts that PIFT has 3 levels now, it is mainly pharmacology that we need and a solid educational component—they would like to see the MCPB bolster the PIFT with a unified program that starts anew with education and pharmacology. Judge echoed Marcolini and also suggested that patient selection needs to be honed for CCT. Liebow added that the supervisory component needs to be solid with solid QI. Diaz believes we need to overtly state stable vs unstable patient with physiologic parameters dictating unstable, and we should develop standing orders for what the medics should expect for “packaged patients” from the ED or ICU’s. Stuchiner pointed out that the protocol book white pages define should define stable. Marcolini asked us for definition of stability and support for new and comprehensive PIFT program.

Action: MDPB reps to the Education Committee will be Collamore, Liebow, and Diaz. We will move as above with revamped PIFT that bolsters the education, pharmacology, and QI components.

12. Vasopressin: We will not change our practice based on NEJM January 8, 2004 p. 105 article by Wenzel *et al*—this study did not follow patients to hospital discharge with neurologic outcomes reported.

Next Meeting March 17, 2004 because of February vacation